Family Information:

Child's Name: _____

Name(s) of Sibling(s): _____

Previous Care:

Has your child been in care before? ☐ Daycare ☐ Home Care ☐ Other: _____ ☐ No

Has your child had any group experience? ☐ Yes ☐ No

Has your child been cared for by anyone other than the parents? ☐ Yes ☐ No
If **yes**, by whom and how long? _____

Play Experience:

Does your child play outside other than being walked in a stroller? ☐ Yes ☐ No

Have you introduced art and/or sensory activities to your child? ☐ Yes ☐ No
If **yes**, please describe _____

What are some of your child's favorite toys, activities, and songs: _____

_____

Social/Emotional Interactions:

Please describe your child's interactions with:

Adults: _____

Other Children: _____

Does your child experience "separation anxiety"? ☐ Yes ☐ No
If **yes**, what method do you use to help alleviate this anxiety? _____

_____

How does your child behave when you depart & return? _____

Does your child experience "stranger anxiety"? ☐ Yes ☐ No
If **yes**, how do you help your child ease through this phase? _____

Generally, how does your child adapt to new situations? _____

How do you reward or reassure your child? _____

Communication:

What is the primary language spoken in your home? ☐ English ☐ French ☐ other

_____

Does your child communicate by: ☐ crying ☐ pointing ☐ babble ☐ words ☐ other

_____

Does your child use sign language to communicate: ☐ Yes ☐ No
If **yes**, what signs are they using? _____

Physical Development:
Does your child? ☐ sit ☐ crawl ☐ stand ☐ walk

Diapering Routine:
Does your child fuss when wet? ☐ Yes ☐ No

Does your child fuss when they have a bowel movement? ☐ Yes ☐ No

Does your child have a history of sensitive skin (diaper rash)? ☐ Yes ☐ No

Does your child require cream/Vaseline for every change? ☐ Yes ☐ No

Sleep Routine:
☐ Morning Nap time: _____ Length of Nap: _____

☐ Afternoon Nap time: _____ Length of Nap: _____

Does your child sleep in his/her own bed or crib? ☐ Yes ☐ No

Does your child sleep on: ☐ stomach ☐ back

Is your child a: ☐ light sleeper or ☐ sound sleeper

Does your child use: ☐ soother ☐ sleep blanket ☐ stuffed toy

Do you ☐ rock him/her ☐ pat his/her back **or** do they ☐ go to the sleep on their own

Any additional information to make nap time more pleasant for your child _____
_____

Safe Sleep Practices for Children less than 12 months of age:

The Public Health Agency of Canada recognizes Sudden Infant Death Syndrome (SIDS) and other infant deaths that occur during sleep as major public health concerns. The Public Health Agency of Canada suggests the following practices be followed:

a. Always place the infant on his or her back to sleep.
b. No extra items in the crib. (ex. Pillows, blankets, stuffed toys)

☐ I will provide a sleep sack for my child to use until they reach 12 months of age.
☐ I have read and understand the concerns from the Public Health Agency of Canada and would like my child to use a blanket during rest times.

Parent's Signature: _____ **Date:** _____
by typing your name above you agree to the above statements

Nutrition:

Have you introduced solid foods to your child? ☐ Yes ☐ No

How do you serve solid food to your child? ☐ Spoon ☐ Bowl/Plate ☐ On Tray

Will you be providing food from home? ☐ Yes ☐ No ***Baby food must be provided***

What beverage(s) that your child drink: ☐ Formula ☐ Homo Milk ☐ Water ☐ Soy Milk ☐ 2% Milk

Formula must be prepared prior

Does your child use a bottle? ☐ Yes ☐ No If **yes**, what times: _____

Does your child hold his/her own bottle? ☐ Yes ☐ No

At what temperature does your child take his/her own bottle? ☐ Heated ☐ Room Temperature ☐ Cold

How do you heat his/her bottle? ☐ Microwave ☐ Hot Water

Is your child currently being Breastfed? ☐ Yes ☐ No If **yes**, what times: _____

Will you be providing breast milk for us to give during the day? ☐ Yes ☐ No

Parent's Signature: _____ **Date:** _____

by typing your name above you agree to the above statements